Note: The authors have worked to ensure that all information in this book concerning drug dosages, schedules, and routes of administration is accurate as of the time of publication and consistent with standards set by the U.S. Food and Drug Administration and the general medical community. As medical research and practice advance, however, therapeutic standards may change. For this reason and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of a physician who is directly involved in their care or in the care of a member of their family.

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CHAPTER 13
MOOD DISORDERS

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One knows not whether there can be human compassion for anemia of the soul. When the pitch of life is dropped and the spirit is so put over and reversed that only is horrible which before was sweet and worldly and of the day, the human relation disappears.

—Oliver Onions

Mood disorders can be relatively straightforward, or they can assume complex forms that can be difficult to treat. In this chapter, we review the epidemiology, diagnosis, comorbidity, and treatment of the wide variety of affective syndromes that are encountered in psychiatric practice.

EPIDEMIOLOGY

Estimates of the incidence and prevalence of mood disorders vary. In the United States, the lifetime risk of a major depressive episode is said to be around 6%, and the lifetime risk of any mood disorder is said to be around 8% (Cassem 1995; Kashani and Nair 1995). The prevalence of major depression ranges from 2.6% to 5.5% in men and from 6.0% to 11.8% in women (Fava and Davidson 1996). The prevalence of dysthymia is 3%–4% (Keller et al. 1996). Some reports suggest that as much as 48% of the United States population has had one or more lifetime mood episodes (Cassem 1995). Most studies have found unipolar depression in general to be twice as common in women as in men (Reynolds et al. 1990). The meaning of the gender difference remains to be clarified. Gender does not appear to affect the prevalence of bipolar disorder (Reynolds et al. 1990). The incidence of major depression is higher in separated or divorced people than in married individuals, especially men, and in medically ill patients (Lehtinen and Joukamaa 1994; Reiger et al. 1988), and depression is associated with greater use of general health services

that the apparent personality disorder might be an early-onset trait-like variant of other depressive disorders. This hypothesis is supported by the existence of a familial association between depressive personality disorder and other depressive disorders (American Psychiatric Association 1994a) and by earlier onset and more depressive episodes in patients with MDD and a premorbid depressive personality than in patients with major depression but without this premorbid temperament (Cassano et al. 1992).

From a clinical standpoint, defining a personality disorder that overlaps with but is distinct from primary mood disorders has the theoretical benefit of identifying a group of patients who would be expected to have a poor response to typical treatments for depression and a better response to specialized psychotherapeutic approaches. However, the overlap between abnormal mood and stable personality traits is often so extensive that it is indistinguishable (Shea and Hirschfeld 1996). Obviously, many people with diagnoses of MDD and/or dysthymia meet DSM-IV symptomatic criteria for depressive personality disorder. In one study, 41% of patients with a major depressive episode were found to meet all criteria for depressive personality disorder, including persistence of symptoms when the full mood disorder was not present (Shea and Hirschfeld 1996).

The impact of an abnormal mood on thinking and behavior is so profound that it can distort most assessments of personality, making it impossible to determine the degree to which a personality disorder is present when a primary mood disorder and a personality disorder appear to coexist. Chronically unstable or depressed mood can intensify pathological defenses and can skew the ways in which a person experiences the self and others (Deitz 1995). On personality inventories, depressed people resemble each other more than they resemble themselves when they are not depressed (Hirschfeld et al. 1989; Loranger et al. 1991). In several studies, more than 50% of patients (or their relatives) with a diagnosis of borderline personality disorder were found to develop major depression, mania, or hypomania or commit suicide (Akiskal 1984, 1991). This finding could indicate a high rate of comorbidity or an aggravation of pathological personality traits by subclinical mood disorders that are not obvious until they eventually become severe enough to be recognized. Because mild depressive symptoms as well as social impairment can persist after remission of a full depressive syndrome, persistent passivity, negative thinking, low self-esteem, cynicism, and related traits in the absence of a diagnosable mood disorder could represent residual symptoms of a previous episode or prodromal symptoms of another episode, rather than a true personality disorder. In the absence of any validated method of distinguishing the two, the most prudent approach for the clinician is to treat depression as vigorously as possible before diagnosing a personality disorder. However, the fact that psychological issues that can interfere with the response of mood disorders to standard treatments—such as negative therapeutic reactions, attachment to a negative view of the self and others, self-destructive motivations, and treatment nonadherence—may not always be diagnostic of a personality disorder does not mean that it is possible to ignore these issues in treatment.

PSYCHOTIC DEPRESSION

The term *psychotic depression* (or *delusional depression)* refers to a major depressive episode accompanied by psychotic features (i.e., delusions and/or hallucinations). Some clinicians believe that psychotic depression is relatively uncommon. However, most studies continue to demonstrate that 16%–54% of depressed patients have psychotic symptoms (Dubovsky and Thomas 1992). Delusions occur without hallucinations in one-half to two-thirds of adults with psychotic depression, whereas hallucinations are unaccompanied by delusions in 3%–25% of patients (Dubovsky and Thomas 1992). Hallucinations occur more frequently than delusions in younger depressed patients and in patients with bipolar psychotic depression (Chambers et al. 1982; Goodwin and Jamison 1991). Half of all psychotically depressed patients experience more than one kind of delusion (Dubovsky and Thomas 1992). The common belief that visual and olfactory hallucinations are signs of neurological disease and do not occur commonly in mood disorders has been contradicted by clinical experience, which demonstrates that auditory and visual hallucinations are equally frequent and that olfactory hallucinations are not uncommon in psychotic depression (Dubovsky and Thomas 1992).

The classification of psychotic symptoms as mood congruent (i.e., consistent with a depressed or elated mood) or mood incongruent is complex. Prominent mood-incongruent psychotic symptoms in depressed patients such as delusions of control, along with poor adolescent adjustment, may be associated with a somewhat worse prognosis of psychotic depression (K. S. Kendler 1991; D. Tsuang and Coryell 1993). The RDC, which were used in many earlier studies of psychotic depression, indicate a diagnosis of schizoaffective disorder in depressed patients with concurrent mood-incongruent psychotic features. However, bipolar psychotic depression is frequently associated with mood-incongruent psychotic symptoms, some of which may be bizarre and easily mistaken for typical

"schizophrenic" symptoms (Akiskal et al. 1983, 1985; McGlashan 1988); a formal thought disorder occurs in at least 20% of psychotically depressed patients (Goodwin and Jamison 1991). Because bipolar illness is overrepresented in psychotic depression (Coryell 1996; Weissman et al. 1988a), it may be bipolar illness and not mood incongruence that contributes to a poorer treatment response in mood-incongruent psychotic depression. In recognition of the uncertain contribution of mood incongruence to the prognosis, DSM-IV requires the existence of psychotic symptoms for 2 or more weeks in the absence of prominent mood symptoms for a diagnosis of schizoaffective disorder, a feature that seems more consistently associated with a somewhat poorer prognosis of mixed affective and psychotic syndromes (Coryell 1996).

Recognizing psychotic symptoms in depressed patients is not always straightforward. If the patient does not seem severely depressed (this can occur in patients with bipolar psychotic depression who have a mixed element of elevated mood and energy that makes them appear less depressed than they feel), the clinician might not inquire about psychotic symptoms in the first place. Some patients do not consider hearing voices or ideas of reference to be abnormal and do not report such symptoms. Other patients conceal psychotic symptoms because they do not want to be considered "crazy." To be certain that psychotic symptoms are not present, it may be necessary to ask repeatedly about them, beginning with nonspecific questions such as "Does your mind ever play tricks on you?" and progressing gradually to more specific questions such as "Do you ever hear your name called when there's no one there?" and then "Do you ever hear a voice saying more than your name?"

Psychotic features tend to develop after several episodes of nonpsychotic depression. Once psychotic symptoms occur, they reappear with each subsequent episode, even if later episodes are not as severe. With each recurrence, psychotic symptoms take the same form that they did in previous episodes (e.g., patients with hallucinations have them in the same modality and with the same content from episode to episode) (Dubovsky and Thomas 1992). Relatives of psychotically depressed patients have an increased risk of psychotic depression themselves; and when psychotic depression is present, the content of the psychosis tends to be similar to that of the proband. The families of psychotically depressed patients also have an elevated risk of schizophrenia.

Whereas treatment with both an antipsychotic drug and an antidepressant is usually necessary for a remission of psychotic depression, antipsychotic drugs may improve the depression and the antidepressant may improve psychosis (Dubovsky and Thomas 1992). Further, coaggregation of severe mood disorders and schizophrenia exists in families of patients with psychotic depression. These two observations suggest that psychotic depression is not a simple combination of psychosis and depression but rather a complex interaction between the capacity to become psychotic and the capacity to become severely depressed (Dubovsky and Thomas 1992). Depression may have to reach a certain level of severity for psychosis to be expressed; but once psychosis develops, a unique disorder has evolved. Some features in addition to the unique treatment response that distinguish psychotic from nonpsychotic depression include a greater rate of recurrence; a higher suicide risk; more nonsuppression on the dexamethasone suppression test (DST), with higher post-dexamethasone cortisol levels; more prominent sleep abnormalities; and higher ventricle-to-brain ratios (Coryell 1996; Dubovsky and Thomas 1992). The extent to which the symptomatology, course, and treatment response of psychotic depression are a function of psychosis itself or the overrepresentation of bipolar disorder in psychotically depressed patients (Weissman et al. 1988a) has not been studied.

RECURRENT BRIEF DEPRESSION

Both the RDC (M. T. Tsuang and Faraone 1996) and DSM-IV criteria (First et al. 1996; M. T. Tsuang and Faraone 1996) require 2 weeks of continuous symptoms for a diagnosis of a major depressive episode to be made. Researcher Jules Angst and his colleagues elucidated a depressive disorder called *recurrent brief depression* in which depressive episodes meet DSM-IV symptomatic but not duration criteria for major depression. Depressive episodes in recurrent brief depression have the same number and severity of symptoms as DSM-IV major depressive episodes but last 1 day to 1 week (Keller et al. 1996). Depressive episodes must recur at least once per month over at least 12 months (not in association with the menstrual cycle) for recurrent brief depression to be diagnosed (Angst and Hochstrasser 1994). Although each acute depressive episode is short-lived, recurrent brief depression carries a high risk of suicide (Lepine et al. 1995), perhaps because of the inevitable return of depression and the repeated drastic contrast between the depressed and well states.

The appendix to DSM-IV lists recurrent brief depressive disorder defined by Angst's criteria as a condition requiring further study because it was thought that not enough data had accumulated to warrant its inclusion as an established diagnosis (American Psychiatric Association